CHAPTER VI

UTILIZATION REVIEW

CHAPTER VI
TABLE OF CONTENTS

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients. Federal regulations at 42 CFR 455-456 set forth requirements for detection and investigation of Medicaid fraud and abuse to maintain program integrity and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services.

This chapter provides information on utilization review and control requirements handled by DMAS. The general information sections are followed by specific utilization control requirements that apply to the specific programs and services covered in this manual.

REVIEW AND EVALUATION OVERVIEW

DMAS routinely conducts utilization review to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. Participating Medicaid providers are responsible for ensuring that requirements such as record documentation for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request.

Providers and recipients are identified for review either from systems generated reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Some provider reviews are initiated on a regular basis to meet federal requirements. DMAS reviews claims for services provided by or resulting from referrals by authorized PCPs in managed care and utilization control programs. In some programs, random sampling may be used to determine areas for on-site reviews. There are also computerized exception reports which look at utilization patterns for providers and recipients. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. Exception reports for recipients are developed by comparing individual recipient's medical services utilization with those of the recipient peer group. An individual exception profile report is generated for each recipient and provider who exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary. Statistical sampling may be used in a review.

The use of statistical sampling is recognized as a valid basis for findings of fact in the context of Medicaid reimbursement. DMAS may utilize a scientific random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the number and amount of invalid dollars paid in the audit sample is compared to the total number and amount of dollars paid for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to regulation or statute, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Corrective actions for recipients include education on the appropriate use of health care, restriction to designated providers for utilization control, recovery of misspent funds, and referral for further investigation of allegations of fraudulent activities. Loss of Medicaid coverage can result from a conviction of Medicaid fraud.

OVERVIEW OF DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS) UTILIZATION REVIEW

DMAS Utilization Review is conducted periodically to assure that individuals receiving Medicaid elderly case management services meet the requirements for the service. DMAS review also assures that quality services are being received which are appropriate, cost-effective, and adequate to maintain the recipient in a healthy and safe environment.

DMAS staff perform utilization reviews through:

- Review and authorization of case management services;
- On-site review of the individual recipient's records to review the case manager's documentation which details the recipient's status and the services provided each month;
- Review of the invoices submitted during the month;
- Home visits completed with the recipient to review the satisfaction with the services and the quality of care; and
- Provider agency review completed annually to assure the continued compliance with the provider participation standards.

AUTHORIZATION

WVMI will review the request for authorization and process the authorization package for payment of case management. If elderly case management has been recommended and appears appropriate, the WVMI analyst will notify the provider agency in writing of the

effective date case management services are authorized. The authorization will then be entered in the Medicaid Management Information System (MMIS) to enable service providers to bill for the services rendered.

DMAS will notify the provider in writing when billing for case management services has been authorized.

RECIPIENT HOME VISIT

DMAS utilization review staff will conduct a home visit annually to a sample of recipients receiving elderly case management services. The purpose of the home visit is to:

- Ensure that the amount, duration, and scope of the services are appropriate and that the services are being rendered according to the plan of care;
- Address the quality of care issues with the recipient and determine the satisfaction with the services; and
- Ascertain that contacts are being made by the case manager according to DMAS policy.

The interview with the recipient and the primary caregiver will be conducted in a manner which encourages an open discussion between the recipient, the caregiver, and the DMAS representative. This representative will gather information from the recipient and primary caregiver regarding their satisfaction with services. Satisfaction with services can be determined by a discussion of the recipient's assessment of the:

- Appropriateness of the care plan;
- The continuity of service provided by the service providers;
- The recipient's access to the case manager; and
- The ability to resolve problems in a meaningful manner.

Any problem areas which have been identified may be discussed and a plan for resolution identified. The case manager will be informed of the content of this meeting so that follow-up of any problem areas can be made.

REVIEW OF PROVIDER STANDARDS AND DOCUMENTATION

The provider review will be completed by a DMAS representative on an annual basis. This review is performed to assure continued compliance with Medicaid provider participation standards. Staff credentials will be reviewed for those case managers providing services. Provider documentation will be reviewed for the identification of any quality of care issues such as:

- Lapses in services;
- Staffing the case with unqualified staff;
- Failure to identify problems;
- Failure to follow up on problems; or
- Failure to make the appropriate referrals or to communicate adequately with the family, service providers, or others.

DOCUMENTATION REQUIREMENTS: GENERAL

The record must contain sufficient information to clearly identify the recipient, to justify the services provided, and to document the results accurately. All records must contain documented evidence of the assessment of the needs of the recipient, of an appropriate plan of care, and of the care and services provided; identification data and consent forms, monthly logs and progress notes; and a discharge summary including the services that the individual has received and will be receiving upon discharge.

The provider must maintain records on all recipients in accordance with accepted professional standards and practice. Records must be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieval and compilation of documentation.

All record documentation must be signed with the initials, last name, and title and be dated with complete dates (month, day, year).

COMPONENTS OF REVIEW

Case management providers are continually assessed to assure conformance with Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, continuous monitoring of service delivery, service need re-evaluation, and the coordination of services to dependent elderly individuals residing in the participating geographic areas. Information used by DMAS to make this assessment includes DMAS desk review of documentation submitted by the provider as well as on-site review of provider files and visits to recipient's homes. The DMAS assessment of the provider is based on a comprehensive evaluation of the provider's overall performance in the following areas:

- Assessment of Individual Need and Plan of Care Development: The case manager assigned to an elderly recipient is responsible for continually assessing the need and for making the necessary revisions to the plan of care to assure the recipient's health and safety. Elderly recipients must continue to meet the criteria for case management services (i.e., live in the geographic areas and be dependent in two activities of daily living) during any period in which case management services are rendered, and the plan of care must

accurately reflect the recipient's needs and correlate to the services rendered to that recipient.

- Adherence to the Plan of Care: It is the case management provider's responsibility to monitor the provision of services to ensure that the services needed are being received and that they are meeting the recipient's needs in a timely manner.

- Monthly Logs and Progress Reports: The documentation maintained by the case manager must accurately summarize the contacts between the case manager and the recipient. This documentation must reflect a reassessment of the recipient's need for services and appropriateness of the plan of care at least every six months as well as ongoing monitoring of the recipient's assessed needs and the service delivery system coordinated for that recipient. The case manager's documentation must also serve as an audit trail of case management activity reimbursed by DMAS.

- Billing: Case management services must be documented and match the claims submitted to DMAS by the provider.

Documentation Required - Recipient Record

The case management provider agency shall maintain all records for each case management recipient. These records shall be reviewed periodically by DMAS. The case manager is responsible for maintaining a file for each recipient which includes:

- The recipient's screening assessment documentation (Uniform Assessment Instrument and Plan of Care);

- All subsequent revisions to the Plan of Care;

- A monthly log which lists the dates and duration of all contacts between case management provider staff and the recipient and summarizes the nature of those contacts. DMAS recommends use of the Elderly Case Management Services Monthly Progress Log and Summary form as a log sheet and summary report. However, this form is not required, and the log may be maintained in any format chosen by the case manager, as long as all data required by DMAS are included. The log must be maintained by the case manager.

- A 30-day recipient progress report maintained by the case manager which summarizes on a monthly basis the recipient's status (e.g., any change in the recipient's medical status, service needs, social support, and the hospitalization admission and discharge dates), the reason for any changes to the plan of care and which documents all communications between the case manager, other service providers, family, physicians, DMAS, WVMI, and all other professionals concerned with the recipient. This progress report must also document the semi-annual re-evaluation of the recipient's need for continued service. DMAS recommends use of the Elderly Case Management Services

Monthly Progress Log and Summary form as a log sheet and summary report. However, this form is not required and the log may be maintained in any format chosen by the case manager as long as all data required by DMAS are included; and

- Copies of correspondence pertaining to the recipient.

The case manager is responsible for reviewing and revising plan of care as often as necessary, but no less than every six months. This review must be documented in the recipient's file. The documentation must note all members of the case management team who provided input to the plan of care.

DMAS will review the provider's performance in all of the above areas to determine the provider's ability to achieve a high quality of care and to conform to DMAS policies. The purpose of this provider review is to provide feedback to the provider regarding those areas which may need improvement.

The Provider Standards and Documentation Form will be completed during this review and a recommendation will be made regarding the agreement renewal by the Department of Medical Assistance Services.

Services not specifically documented in the recipient's record as having been rendered will be deemed not to have been rendered, and any payment shall be recovered by DMAS.

RECONSIDERATIONS AND APPEALS

Payment to the elderly case management provider may be denied or retracted when the provider has failed to comply with established DMAS federal and state regulations and policy guidelines, or both.

The provider has a right to request reconsideration of denials. The request for reconsideration and all supporting documentation, must be submitted within 30 days of written notification to:

DMAS
Attn: Waiver Services Supervisor
600 East Broad Street, suite 1300
Richmond, VA 23219

The DMAS Supervisor will review the documentation submitted and provide the elderly case management provider with a written response to the request for reconsideration. If the denial is upheld, the provider has the right to appeal the reconsideration decision by requesting an informal fact finding conference within 30 days of written notification of the reconsideration decision. The provider must submit a detailed statement of the factual and legal basis for each item under appeal. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the denial is upheld, the provider has the right to appeal the informal fact finding decision by requesting a formal evidentiary appeal within 30 days of written notification of the informal fact finding decision. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

See Chapter II for additional information on reconsiderations and appeals.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 East Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations regarding issuance of non-entitled benefits or fraud or abuse by non-providers, or both, are investigated by the DMAS Recipient Audit Unit. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid or failed to report changes that, if known, would have resulted in ineligibility, or both. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that non-entitled benefits were issued, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provision of the *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of 12 months beginning with the month of the fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) in DMAS. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy, or both, in the Client Medical Management Program (CMM). (See "Exhibits" at the end of Chapter I for detailed information on the CMM Program.) If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589
FAX: (804) 786-5799

When making a referral, provide the name and Medicaid number of the recipient and a brief statement regarding the nature of the utilization problems. Hospitals continue to have the use of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.